Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INSURANCE CO OF THE STATE OF PA
PO BOX 201329
AUSTIN TX 78720-1329

Respondent Name and Address

SOUTHWEST SURGICAL HOSPITAL
1612 HURST TOWN CENTER DR
HURST TX 76054-6236

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-2253-01
(formerly M4-06-0818-01 and M4-05-B797-01)

MFDR Date Received

August 22, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Ward North America received Southwest Surgical Hospital bill on May 3, 2005 for $30,287.75. . . . a good faith payment of 45% of the bill amount was paid $13,629.48 on May 03, 2005. . . . Ward North America requested refund of $4670.59 on June 3, 2005, and mailed Explanation of Review to Provider. . . . Southwest Surgical Hospital received our request for refund on June 6, 2005 certified mail and signed for it. . . . Southwest Surgical has not appealed the payment or review."

Amount in Dispute: $4,670.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The health care provider did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2005 to April 3, 2005	Inpatient Hospital Services	$4,670.59	$4,670.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.304 sets out the rules for medical bill payments, denials and refunds.
2. Former 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.
3. Former 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. Former 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
5. Former 28 Texas Administrative Code §134.803 sets out the rules for calculating interest for late payment of medical bills and refunds.

6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 080 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF
     - $0.00
     - $12,043.44
     - $18,244.31
   - 854-003 – CPT CODE/MODIFIER PAID ACCORDING TO DOCUMENTATION FROM AMA STATE ALLOWABLE CODES. RESULTS OF PROFESSIONAL REVIEW (RN, MD, DC, CPC, OTHER MEDICAL PROFESSIONAL)
     - $2,236.00
     - $6,722.89
     - FEE GUIDELINE MAR REDUCTION $0.00
     - FEE GUIDELINE MAR REDUCTION $18,244.31

Issues

1. Did the insurance carrier meet the requirements for requesting refund of an overpayment?
2. Did the health care provider meet the requirements for responding to the refund request?
3. What is the recommended reimbursement for the healthcare provider's services?
4. What is the additional recommended reimbursement for implantable items?
5. What is the additional recommended reimbursement for pharmaceuticals?
6. Is the requestor entitled to reimbursement for an overpayment?
7. What was the 60th day after the date the health care provider received the request for the refund?

Findings

1. This dispute relates to a request by the insurance carrier for reimbursement of an overpayment to the health care provider. Former 28 Texas Administrative Code §§ 133.304(a) and (b), effective July 15, 2000, 25 *Texas Register* 2115, required that "an insurance carrier shall take final action on a medical bill not later than the 45th day after the date the insurance carrier received a complete medical bill. . . . Final action on a medical bill includes one or more of the following: (1) sending payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . . ; (2) denying a charge on the medical bill; or (3) requesting reimbursement for an overpayment." Review of the submitted documentation finds that the requestor sent both payment and a refund request to the health care provider within 45 days of receipt of the medical bill. The Division concludes that the requestor has met the requirements of §§134.304(a) and (b).
2. Former 28 Texas Administrative Code §133.304(o) required that "A health care provider who receives a request for the refund of payment for medical treatment(s) and/or service(s) shall, by the 45th day after receipt of the request: (1) pay the request; or (2) submit to the insurance carrier a specific explanation regarding the reason the health care provider has failed to make the payment requested." No documentation was found to support that the health care provider paid the request or submitted an explanation to the insurance carrier regarding the reason the health care provider failed to make the requested payment. The Division concludes that the health care provider has not met the requirements of §133.304(o). The disputed overpayment will therefore be reviewed for refund in accordance with applicable Division rules and fee guidelines.
3. The disputed overpayment relates to inpatient hospital services with reimbursement subject to the provisions of the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264. §134.401(c) requires "workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services." Review of the submitted documentation finds that the length of stay was 2 days. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 2 days yields a reimbursement amount of $2,236.
4. Additionally, per §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%. Review of the submitted records finds that the health care provider billed revenue code 278 for implantable items including:
   - "IMP DEPUY PLT 2-LVL 41MM 174902041" as identified in the itemized statement and labeled on the invoice as "2 level Cervical Plate 41mm" with a cost per unit of $1,262.99;
   - "IMP DEPUY HEALOS II 276160010" as identified in the itemized statement and labeled on the invoice as "Healos II Strips" with a cost per unit of $1,416.45;
   - "IMP DEPUY BONE GRAFT T79" as identified in the itemized statement and labeled on the invoice as

"Tissue Code VG2C T79" with a cost per unit of $995.00;

- "IMP DEPUY BONE GRAFT T68" as identified in the itemized statement and labeled on the invoice as "Tissue Code VG2C T68" with a cost per unit of $995.00;
- "IMP DEPUY SCR 4 X 12MM 174915012" as identified in the itemized statement and labeled on the invoice as "4x12 mm Screws" with a cost per unit of $225.38 at 6 units, for a total cost of $1,352.28.

The provider submitted purchase orders supporting that the cost to the hospital of these implantable items was $ 6,021.72. 10% of this amount is $ 602.17. The total recommended reimbursement amount for the implantable items is $6,623.89.

5. Former 28 Texas Administrative Code §134.401(c)(4)(C) requires that "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%." Review of the submitted records finds insufficient information to determine whether the healthcare provider billed for any pharmaceuticals exceeding $250.00 per dose. Moreover, review of the submitted information finds no documentation of the cost to the hospital of the disputed pharmaceuticals. Therefore, no additional reimbursement can be recommended for the disputed pharmaceuticals.
6. The total allowable reimbursement for the services in dispute is $8,859.89. The submitted documentation supports that the insurance carrier has paid $13,629.48. The requestor is seeking a refund in the amount of $4,670.59. This amount is recommended.
7. Additionally, §133.304(r) requires that "All refunds requested by the insurance carrier and paid by a health care provider on or after the 60th day after the date the health care provider received the request for the refund shall include interest calculated in accordance with §134.803 of this title. Interest shall be paid from the 60th day after the date of receipt of the request for refund to the date of payment. Review of the submitted signed certified mail return receipt finds that the health care provider received the insurance carrier's refund request on June 6, 2005. The Division notes that the 60th day after the date of receipt was August 5, 2005 for the purposes of calculating interest in accordance with §133.304(r) and §134.803.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that a refund for an overpayment is due. As a result, the amount ordered is $4,670.59 plus applicable accrued interest.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement of an overpayment related to services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,670.59 plus applicable accrued interest per former 28 Texas Administrative Code §133.304(r) and §134.803, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	February 8, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.